REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

172.5

REVIEW OF THE ADMINISTRATION BY THE DEPARTMENT OF HEALTH OF CONTRACTED PREPAID HEALTH PLANS WITH THE FOUNDATION COMMUNITY HEALTH PLAN AND THE AMERICAN HEALTH CARE PLAN

APRIL 1975

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500–10504

California Legislature

BOB WILSON
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May 5, 1975

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of
the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

I am today releasing the report of the Auditor General on the review of the administration by the State Department of Health of the Foundation Community Health Plan (FCHP) and American Health Care Plan (AHCP), prepaid health plans (PHPs) under contract with the department. FCHP and AHCP provide health care services to Medi-Cal recipients. Payments for these services are made by the state to the PHPs on a prepaid, fixed fee per capita basis.

The Department of Health paid FCHP approximately $16.1 million in fiscal year 1973-74 for providing such services in Sacramento, Yolo, Placer, El Dorado and Nevada Counties. The Department of Health paid AHCP approximately $1.7 million between May 1, 1974 and December 31, 1974 for providing such services in San Francisco and San Mateo Counties.

FCHP's and AHCP's current contracts expire on June 30, 1975.

The Auditor General's report has cited the following deficiencies:

- The actual payments made in 1974 by the Department of Health to FCHP for providing health care services to Medi-Cal recipients exceeded the estimated fee-for-service costs to provide such services by approximately $1.6 million. This excess payment has not been supported by actuarial data as required by the Welfare and Institutions Code.

- FCHP does not have the statutorily required financial resources to contract with the state as a prepaid health plan. FCHP has never maintained the amount of equity required of PHPs under the Welfare and Institutions Code and Government Code. In fact, contrary to maintaining an equity position, based on FCHP's audited financial statements, FCHP's accumulated deficits as of December 31, 1972, June 30, 1973 and June 30, 1974 were $348,293, $1,912,867 and $1,630,989, respectively.

- Based on an unaudited financial statement, as of February 28, 1975, FCHP had an accumulated deficit of $1,136,316. Also, on this date, FCHP had a balance of $1,652,192 accumulated by withholding fees owed to its health care providers, including private physicians and hospitals. While FCHP's Board of Trustees could take action to use these withheld fees to offset its deficit and to meet its equity requirements, this would mean that its providers would not be fully paid for services rendered.

- AHCP has not maintained medical records of each of its Medi-Cal recipient enrollees as required by the Welfare and Institutions Code. Such inadequate documentation can affect the continuity of care provided to Medi-Cal recipients.

The Auditor General makes the following recommendations for action by the Department of Health:

- Determine the actuarially adjusted fee-for-service rates, and negotiate the contract with FCHP in order that the prepaid health contract costs do not exceed the actuarially adjusted fee-for-service costs.

- Recover from FCHP any portion of the $1.6 million which represents excess payments not supported by actuarial data.

- Unless FCHP's Board of Trustees takes necessary action enabling FCHP to meet the statutorily required financial resources, the contract with FCHP should be canceled.

- Enforce the provisions of the Welfare and Institutions Code requiring AHCP to establish and maintain medical records for each Medi-Cal recipient enrollee.

Unless the excess payments are supported by actuarial data, implementation of the Auditor General's recommendations will result in reduced expenditures to the state of up to $1.6 million annually and in the recovery of an undetermined amount of the $1.6 million in excessive state payments made in 1974 to FCHP.

Other pertinent information noted by the Auditor General's staff is as follows:

- AHCP and certain of its enrollment representatives have been charged with misrepresentation in the enrollment of Medi-Cal recipients by using such statements as "You will lose your Medi-Cal if you don't join". A lawsuit is now pending in court. However, the Auditor General's staff has noted that AHCP's enrollment procedures have now been corrected.

- Inadequate procedures make it possible for PHPs to receive state revenues for up to four months for its Medi-Cal recipient enrollees who have moved and are no longer receiving health care treatment from the PHP.

- Although an interest-free loan of $64,293 was made by the Department of Health, in violation of the Government Code and the Health and Safety Code, to Medical Care Foundation, the contract predecessor of FCHP, the loan was repaid by Medical Care Foundation.

In a response contained in the Auditor General's report, FCHP officials stated that their PHP has operated much better than Medi-Cal fee-for-service. They also stated that their Board of Trustees does not presently intend to pay its medical providers the portion of fees withheld from such providers and, therefore, such monies should not be considered a liability for purposes of the state's net equity requirements.

AHCP officials stated that if it were to maintain medical records of each of its enrollees, subcontractors' records would have to be duplicated, and the costs to do so would outweigh the benefits.

The Honorable Members of the Legislature
of California

The verbatim response of the Chief Deputy Director of the Department of Health is on page 26 of the report.

Respectfully submitted,

Bob Wilson

BOB WILSON, Chairman
Jt. Legislative Audit Committee

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April 24, 1975

Honorable Bob Wilson
Chairman, and Members of the
Joint Legislative Audit Committee
Room 4126, State Capitol
Sacramento, California 95814

Dear Mr. Chairman and Members:

Transmitted herewith is our report on the review of the administration by the State Department of Health of the Foundation Community Health Plan and the American Health Care Plan, prepaid health plans under contract with the department.

Respectfully submitted,

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INTRODUCTION

In response to a legislative request, we have reviewed the administration by the Department of Health of the operations of the Foundation Community Health Plan (FCHP), a Sacramento-based prepaid health plan, and the American Health Care Plan (AHCP), a San Francisco-based prepaid health plan.

The FCHP and AHCP provide health care services to Medi-Cal recipients. Payments for these services are made by the state to FCHP and AHCP on a prepaid, fixed fee per capita basis under separate contracts with the State Department of Health.

The review was confined to the administrative functions of the prepaid health delivery program of FCHP and AHCP. No attempts were made to evaluate the quality and adequacy of the health care provided by the plans to the enrollees.

As part of the review, we visited the prepaid health plans and their facilities, and contacted the administrative and accounting personnel of both plans. We contacted the prepaid health plan development and management staff of the Department of Health, the administrative personnel of the state fiscal intermediaries processing Medi-Cal claims under fee-for-service, and county welfare department personnel of Sacramento and San Francisco Counties. We also contacted various providers of health care services and interviewed selected enrollees of the plans.

We selected random samples of Medi-Cal recipients enrolled in FCHP and AHCP during the 1973-74 fiscal year. The periods of eligibility and payment

histories of each selected recipient were checked against Medi-Cal beneficiary payment history profiles and to the health plan's unit patient records.

The audited financial statements of FCHP for 1972, 1973 and 1974 and those of AHCP for 1973 and 1974 were reviewed and analyzed. Oral representations made by officials and employees of the prepaid health plans were verified and agreed with supporting data and schedules supplied to us during the course of the review.

Foundation Community Health Plan (FCHP)

FCHP is a nonprofit health service plan and provides health care services to Medi-Cal recipients in Sacramento, Yolo, Placer, El Dorado and Nevada Counties on a prepaid basis under a contract with the State Department of Health. FCHP's office is located in Sacramento. The plan became operational on July 1, 1972.

FCHP is sponsored by the Medical Care Foundation of Sacramento, an organization of the Sacramento County Medical Society. FCHP provides health care services through subcontracts with physicians, hospitals, pharmacies and other providers of health care throughout its five-county service area. Physician members of FCHP are also members of the medical societies of the five counties. FCHP receives a fixed monthly fee for each Medi-Cal recipient enrolled in the plan on a prepaid basis (capitation revenue) from the Department of Health and pays the providers of health care services on the basis of prearranged and adjusted fee-for-service rates.

FCHP's one-year contract expired on October 31, 1974. A new contract is being negotiated with the plan. However, the Department of Health approved the extension of the FCHP contract to run until January 31, 1975 and reextended the contract until June 30, 1975.

FCHP has a contract maximum allowable enrollment of 75,000 Medi-Cal recipients. As of March 1, 1975, 37,847 recipients were enrolled in the five-county service area of FCHP. The monthly capitation revenue received by the plan from the state at this enrollment level is approximately $1.38 million.

Total prepaid capitation revenues received by FCHP from the state amounted to $8.1 million in the 1972-73 fiscal year and $16.1 million in the 1973-74 fiscal year. Substantial increases in capitation rates paid by the state and increased enrollment during 1973-74 accounted for the nearly 100 percent increase in capitation revenue of FCHP over 1972-73.

American Health Care Plan (AHCP)

AHCP is a nonprofit health service plan. This plan provides health care services to Medi-Cal recipients in San Francisco and San Mateo Counties under one contract with the Department of Health. AHCP's office is located in San Francisco.

Health care services are subcontracted and provided by three medical groups and individual physicians, dentists, pharmacists, hospitals and other health care providers. AHCP pays each member medical group a fixed percentage of the monthly capitation payment received from the state. The medical groups

in turn distribute a certain percentage of the payment to their group physicians. Individual physicians, dentists, pharmacies, hospitals and other providers are paid directly by the plan on a fee-for-service basis.

AHCP was awarded its first contract from the Department of Health for one year beginning on May 1, 1973 through April 30, 1974. The contract was renewed for another year from May 1, 1974 through April 30, 1975, and has been extended through June 30, 1975.

Total prepaid capitation revenues received by AHCP from the state amounted to $740,500 in the period May 1, 1973 through April 30, 1974 and $1,736,000 in the period May 1, 1974 through December 31, 1974. This increase in capitation revenue resulted from higher capitation rates paid by the state and increased enrollment.

AHCP has a contract maximum allowable enrollment of 30,000 Medi-Cal recipients in San Francisco County and 10,000 recipients in San Mateo County. As of March 1, 1975, the total number of recipients enrolled by the plan in the two-county service area was 8,104. The average monthly capitation payment from the state under the renewed contract through December 31, 1974 amounts to $217,000.

FINDINGS

THE EXCESS OF CAPITATION RATES PAID BY THE DEPARTMENT OF HEALTH TO FOUNDATION COMMUNITY HEALTH PLAN FOR MEDICAL SERVICES TO MEDI-CAL RECIPIENTS OVER COSTS ON A FEE-FOR-SERVICE BASIS ARE NOT SUPPORTED BY ACTUARIAL DATA AS REQUIRED BY LAW. AS A RESULT, THE STATE PAID AN ESTIMATED $1.6 MILLION MORE IN 1974 FOR PREPAID MEDICAL SERVICES THAN ITS RECORDS SUPPORT.

Section 14301 of the Welfare and Institutions Code provides that the per capita rates payable to a prepaid health plan shall not exceed the department's estimates of the amounts which would be payable if the services covered under the prepaid health plan were paid on a fee-for-service basis after appropriate adjustments to assure actuarial equivalence.

The department has not made any adjustments for actuarial equivalence to support the capitation rates paid to Foundation Community Health Plan (FCHP) for prepaid health care service. Pursuant to the Welfare and Institutions Code, in the absence of such actuarial adjustments, the maximum per capita rate allowable would be the fee-for-service rate. Nevertheless, the actual payments to FCHP in 1974 are estimated to be $1.6 million in excess of the department's estimates of the costs of the services if provided on a fee-for-service basis. This is evidenced by the following memorandum of the Rates and Fees Section of the Department of Health issued on February 21, 1975:

"This memo is to confirm information you requested and which was provided to you earlier regarding the cost impact of cancelling the contract with FCHP. A study was done using MOP [Month of Payment] data for the months of October through December 1974. This study compared average costs by aid category for FCHP and fee-for-service in FCHP counties. The following is a summary of the average monthly costs per eligible:

	AFDC	OAS	AB	ATD
FCHP Capitation Rates	$25.93	$33.93	$56.60	$97.04
Fee-for-Service Average costs in FCHP Counties	21.68	33.83	54.14	82.01

Multiplying these amounts by the number of eligibles by aid type who were enrolled in 1974 by FCHP, it is found that the State paid $2,266,275 more on an annual basis to have FCHP provide medical care than it would have cost under fee-for-service. This estimate assumes there has been no adverse selection for either fee-for-service or FCHP and that within each aid category the average level of care needed by eligibles in both areas is equivalent. No administrative cost factors have been added to the fee-for-service costs."

If these services had been provided on a fee-for-service basis, the estimated administrative costs to the Department of Health for processing claims for these services would have been approximately $661,500. Deducting this amount from the $2,266,275, which the Department of Health estimated as the amount paid to FCHP which exceeded the estimated costs under fee-for-service, results in net excess payments of $1,604,775 for 1974.

The results of this study by the Department of Health confirmed the finding included in our report (172.2) issued on July 10, 1974. In that report we stated that FCHP's per capita rates under the current contract were higher than the estimated fee-for-service cost. In response to this, the then Director of the Department of Health and his staff stated:

> "The Department of Health allowed higher rates to FCHP because the PHP enrollees include a disproportionate number of sick people. The department concluded that this was the case because FCHP made enrollments through physicians' offices and those enrolled were, therefore, in more need of medical care. The department also found a higher incidence of hospitalization for recipients enrolled in the plan."

Documentation to support that FCHP has enrolled a disproportionate number of sick people (adverse selection) has never been furnished to us by either the department or FCHP. If adverse selection were documented, per capita rates paid by the state to FCHP could legally exceed the average costs on a fee-for-service basis, as an adjustment based on such documentation would be an adjustment for actuarial equivalence.

FCHP has contracted with a consulting actuary who has attempted to ascertain the degree of adverse selection, if any. However, the actuary has been unable to demonstrate adverse selection because, according to FCHP, the Department of Health has not made necessary fee-for-service cost and treatment data available.

The scope of this audit did not include any attempt to determine whether adverse selection exists or the degree of any adverse selection.

However, there may be other explanations for the higher costs than just adverse selection. For example, a management study conducted in June 1973 by Department of Health staff reported that the higher per capita costs at that time actually resulted from high fees paid by FCHP to its

health care providers rather than from FCHP enrollees requiring more health care services than normal.

CONCLUSION

The Department of Health spent an estimated $1.6 million more for health care services provided by FCHP during 1974 than its records show the services would have cost on a fee-for-service basis. Neither the department nor FCHP has demonstrated the excess payment was required to assure actuarial equivalence as required by law.

RECOMMENDATIONS

We recommend that the Department of Health determine the fee-for-service rates with appropriate actuarial adjustments and negotiate the contract with Foundation Community Health Plan to provide capitation rates which do not exceed such actuarially adjusted fee-for-service rates.

We further recommend that, after determining the proper capitation rate, the Department of Health recover from FCHP any portion of the approximately $1.6 million which represents excess payments in 1974 not supported by actuarial data.

SAVINGS AND BENEFITS

Implementation of these recommendations will result in capitation rates for Foundation Community Health Plan which do not exceed the statutory maximum. If the excess payments are not justified on the

basis of actuarial equivalence, implementation of these recommendations will also result in reduced annual expenditures of up to $1.6 million and the potential recovery of an undetermined amount of excess state payments which have been made to FCHP.

THE FOUNDATION COMMUNITY HEALTH PLAN DOES NOT HAVE THE STATUTORILY REQUIRED FINANCIAL RESOURCES TO CONTRACT WITH THE STATE AS A PREPAID HEALTH PLAN.

The Welfare and Institutions Code provides that all prepaid health plans contracting with the state must meet and maintain specific financial requirements. The audited financial statements of Foundation Community Health Plan disclose deficits at December 31, 1972, June 30, 1973 and June 30, 1974.

Section 14450(c) of the Welfare and Institutions Code provides that "adequate financial resources", as determined by the Department of Health, shall not be less than the minimum tangible net equity required of health care service plans pursuant to Section 12539 of the Government Code. The term "tangible net equity" as used under Section 12539 of the Government Code means total assets minus total liabilities, after deduction of intangible assets.

FCHP has had an enrollment population in excess of 5,500 family units from August 1972 through March 1975. During this period, the average number of enrolled beneficiaries was 32,185 monthly. The number of beneficiaries enrolled in FCHP as of March 1, 1975 was 37,847. Under provisions of Section 12539 of the Government Code, FCHP, with such enrollment, is currently required to maintain a $40,000 minimum tangible net equity. The tangible net equity requirement has never been met from the time of inception of Foundation Community Health Plan.

Analyses of 1972, 1973 and 1974 audited financial statements of the FCHP support the contention that the required tangible net equity has not been maintained. FCHP's accumulated deficits as shown in the audited statements as of December 31, 1972, June 30, 1973 and June 30, 1974 were $348,293, $1,912,867, and $1,630,989, respectively. Despite the fact that increases in capitation payments from $8.1 million to $16.1 million were made by the Department of Health to Foundation Community Health Plan in the 1973-74 fiscal year, FCHP did not substantially reduce its accumulated deficit at June 30, 1974. We have reviewed the unaudited financial statements of FCHP dated February 28, 1975 and the plan still does not meet the tangible net equity requirements. These statements reflect an accumulated deficit of $1,136,316.

In order to provide incentives to minimize costs, the plan withholds a portion of fees due providers to be paid at such time as FCHP's Board of Trustees deems the organization fiscally able to do so. The accumulation of these funds is called the "provider risk pool". The balance in this account at February 28, 1975 was $1,652,192 or $515,876 in excess of the accumulated deficit as of February 28, 1975. To date the Board of Trustees has not deemed the organization fiscally able to pay any of these withheld amounts.

It may be possible for the Board of Trustees to take action to declare these withheld amounts as contributed capital and thereby offset the deficit balance of the plan to meet the tangible net equity requirements. If this is done, FCHP's health care providers, including private physicians and hospitals, would not be fully paid for services rendered. In any event, until such action is taken by the board the providers' risk pool must be considered a liability due to the providers, which could be paid out at the discretion of the board.

CONCLUSION

Foundation Community Health Plan is still in a deficit position and does not meet the minimum tangible net equity required by statute to contract with the state as a prepaid health plan.

RECOMMENDATION

Unless the Board of Trustees takes necessary action enabling the Foundation Community Health Plan to meet the statutorily required financial resources, we recommend that the Department of Health cancel the prepaid health plan contract with Foundation Community Health Plan.

BENEFITS

Implementation of this recommendation will assure compliance with state law.

THE AMERICAN HEALTH CARE PLAN HAS NOT MAINTAINED MEDICAL RECORDS OF EACH ENROLLEE WHO HAS RECEIVED MEDICAL SERVICES WHILE ENROLLED IN THE PLAN.

Health care services of American Health Care Plan have been provided primarily through four profit-motivated medical groups (now three medical groups). In addition, AHCP subcontracts with for-profit hospitals and with other providers of health care services. No file of medical records of enrollees is maintained by AHCP although this is required by the Welfare and Institutions Code. Section 14455 of the Welfare and Institutions Code states:

> "The prepaid health plan shall maintain a complete medical record for each enrollee including records of treatment rendered by a subcontractor. After July 1, 1975, the prepaid health plan shall maintain a standard medical record for each enrollee and shall maintain a complete unit medical record for each enrollee."

The administrators of AHCP stated that the plan has a decentralized system of record keeping functions involving the treatment and medical care of enrollees by the medical groups and group physicians. The subcontracting medical groups therefore maintain the medical records or treatment charts of AHCP enrollees who have received medical services from the groups. The plan administrators asserted that maintaining a centralized medical record system would not only be difficult but also very expensive.

We selected for review 40 enrollees of AHCP to determine the completeness and adequacy of the medical records being maintained on the enrollees by the member groups and group physicians. Medical records were

found for 12 enrollees. No medical records were found on file for the other 28 enrollees either at the plan headquarters, with the medical groups or with individual member physicians.

It is possible that these enrollees had not received medical care. However, AHCP encountered problems with one medical group and several physicians of this group. Since this group of physicians had been dropped from the plan, it was difficult for AHCP to obtain patient records of enrollees that were included in our review. Because these records were unavailable, we were unable to review the completeness or adequacy of the medical records pertaining to enrollees who were provided medical services by this group of physicians. Also, the existing method of keeping patient records by AHCP made it difficult to trace and identify enrollees who have transferred from one medical group or physician to another in the plan. This lack of adequate documentation of medical treatment provided to enrollees prevents the plan from assuring that continuity of care is provided to enrollees.

CONCLUSION

The current decentralized method of maintaining medical records by American Health Care Plan does not meet the requirement of Section 14455 of the Welfare and Institutions Code and does not provide a basis for assuring continuity of care of enrollees.

RECOMMENDATION

We recommend that the Department of Health enforce the provisions of Section 14455 of the Welfare and Institutions Code which requires American Health Care Plan to establish and maintain medical records for each enrollee.

BENEFITS

Implementation of this recommendation will provide prepaid health plans with adequate medical records of all enrollees of the plans. Such records can be used to assure continuity of care to Medi-Cal recipient enrollees.

OTHER PERTINENT INFORMATION

The following deficiencies were noted from review of the operations of Foundation Community Health Plan and American Health Care Plan and the administration and monitoring by the Department of Health over the prepaid health delivery programs of the two health plans.

The American Health Care Plan And Certain of Its Enrollment Representatives Have Been Charged With Misrepresentation in The Enrollment of Medi-Cal Recipients.

Numerous Medi-Cal recipients have charged enrollment representatives of the American Health Care Plan with misrepresentation when enrolling the recipients in the plan by using such statements as:

- I am with the State Department of Health
- I am with San Francisco welfare department
- You will lose your Medi-Cal if you don't join
- Medi-Cal is being replaced by the plan
- You can still have your own doctor when you join the plan
- You can have any doctor you wish.

As a result of the alleged misrepresentation practices stated above, a lawsuit was filed in the Superior Court of San Francisco County against the plan and the Department of Health. The lawsuit is now pending in court.

One enrollment representative of AHCP enrolled 275 Medi-Cal recipients between January 12, 1974 and March 11, 1974. Of this number of recipients, 119 complained the plan was misrepresented to them and therefore disenrolled; 78 remained in the plan after AHCP's activities and benefits were further explained by the plan's enrollers; and 78 were disenrolled because they were not eligible for prepaid health plan membership.

We reviewed the enrollment and disenrollment records of AHCP for the six months from January 1974 through June 1974. Our review disclosed that 253 family groups had asked for disenrollment from the plan for the following reasons:

- Wished to return to own doctor	139 families
- Charged misrepresentation	43 families
- Did not like service	30 families
- Did not state any reason	27 families
- Encountered transportation problem	9 families
- Moved out from area	5 families
	253 families

During our review AHCP improved its enrollment procedures, and practices mentioned in this report have now been corrected.

Temporary Suspension from Prepaid Health Plans

Numerous complaints have been received by the Department of Health from prepaid health plans, including Foundation Community Health Plan and

American Health Care Plan, which feel that they have been denied revenue to which they are entitled because enrollees experience temporary eligibility problems. One of the major causes of temporary eligibility problems is the late or incomplete filing of the monthly AFDC Eligibility and Income Report (Form WR-7) by Medi-Cal recipients. When this occurs, the prepaid health plan does not receive capitation revenue for that individual for the month in which the form was filed late or was incomplete.

We also found that PHPs have the ability to temporarily suspend members from participating in the plan. This can be accomplished by submitting erroneous information on the eligibility tapes submitted by the plans to the Department of Health. Submission of erroneous information on the eligibility tapes would be reflected on the monthly Prepaid Health Plan Enrollee History Status Report, prepared by the Department of Health, as though the individual were experiencing eligibility problems at the county level.

Department of Health investigators issued a memorandum, dated November 5, 1973, reporting the potential for abuse in this area. The report states in the conclusion: That given

> "...a hypothetical example of a PHP being unaware of an enrollee's preexisting medical condition, and a few months later realize an extensive hospitalization is emminent. They then supply CID with erroneous information resulting in a status change of this person to a five. They allegedly may advise this person that for some unknown reason a computer error originated and it would be to their advantage to contact the DPSS office for a temporary Medi-Cal ID card so this medical condition could be rectified immediately. In essence, the PHP has lost capitation for a short period of time, but the Medi-Cal program pays for the extensive hospitalization. Upon correcting the medical condition, this person could be advised the computer error has been rectified, reactivating the person back on the plan and reinstating the capitation."

In the quotation on the preceding page, CID refers to the Department of Health computer system, and DPSS refers to the county Department of Public Social Services or welfare department, and "a five" refers to the computer print-out code indicating a temporary disenrollment.

We selected a random sample of 181 Foundation Community Health Plan enrollees, temporarily suspended from the plan from the Department of Health's Prepaid Health Plan Enrollees History Status Report as of June 1, 1974. The sample disclosed 22 cases, or 12 percent, where Foundation Community Health Plan enrollees were issued temporary Medi-Cal cards either by the county welfare office or the state and the enrollees were able to obtain medical services under fee-for-service. The balance, or 159 enrollees, received no medical care while they were temporarily disenrolled.

During the month or months that the 22 enrollees received medical treatment under fee-for-service, Foundation Community Health Plan did not receive capitation payments from the department for 181 enrollees. Payments made by the Department of Health on a fee-for-service basis for medical services for the 22 prepaid health plan members temporarily disenrolled were approximately equal to the capitation revenue which the plan did not receive for the total 181 enrollees in the sample who were temporarily disenrolled.

In the above sample, we did not uncover any information which would indicate that Foundation Community Health Plan had submitted erroneous information to the Department of Health.

Although our limited sample did not disclose any loss of revenue to the state, or the plan, there is a weakness in the system and the Department of Health should take corrective action to assure that the prepaid health plans receive all revenues to which they are entitled and that the Department of Health does not pay for extensive medical services which are the responsibility of the prepaid health plans.

Continuation of Capitation Payments To Prepaid Health Plans After the Enrollee Has Moved from the Plans' Service Area

As a part of our review of Foundation Community Health Plan and American Health Care Plan, we contacted the county welfare departments. We discovered that a lack of established procedures has made it possible for prepaid health plans statewide to receive capitation income for up to four months for Medi-Cal recipients who are plan members but who have moved out of the plans' service area and are no longer receiving treatment from the plan.

Department of Health regulations dictate that the county of origin has eligibility responsibility for welfare recipients who move to another county to the end of the month in which the 60th day after notification to the second or third county occurs. The county of origin also retains eligibility responsibility for a period of up to four months if the welfare recipient is "maintaining a home" in the county of origin and plans to return.

The PHPs receive monthly capitation revenue for the Medi-Cal recipients who have moved from the service area until eligibility responsibility is transferred from the county of origin. During this period, the Medi-Cal

recipient can obtain a temporary Medi-Cal card from the second county and obtain medical care under the fee-for-service system. This situation results in significant duplicate payments by the state in that the state pays for the recipient's medical care under a fee-for-service basis as well as making per capita payments to the plan for recipients not receiving their medical care from the plan.

The Department of Health should require county welfare departments to identify, on the eligibility tapes submitted to the Department of Health, those welfare recipients who move from the county. Capitation payments on these individuals should be terminated the month the prepaid health plan member moves out of the plans' service area.

The Department of Health Granted Medical Care Foundation, Contract Predecessor Of Foundation Community Health Plan, A $64,298 Interest-Free Loan in Violation Of Section 1178 of the Health and Safety Code.

A loan agreement was entered on October 10, 1972 between the Department of Health and Medical Care Foundation, the prepaid health plan predecessor to FCHP, to grant Medical Care Foundation an interest-free loan of $64,293, payable in six equal installments of $10,715.50, the first installment beginning on January 25, 1973, and monthly thereafter. As of June 30, 1973, the full amount of the loan was repaid by Medical Care Foundation to the Department of Health.

The purpose of the loan as specified in the agreement was to provide Medical Care Foundation financial assistance to pay a reasonable amount of

administrative, operational and maintenance costs which exceeded its income for the first year of operation. At the time of the loan, however, Medical Care Foundation did not meet the minimum $30,000 tangible net equity required by Section 12539 of the Government Code.

Section 1178 of the Health and Safety Code states in part:

> "A health maintenance organization is eligible for assistance under this part if it satisfies all of the following requirements: ...
>
> "(i) The health maintenance organization has adequate financial resources to carry out its contract obligations. For the purposes of this section, 'adequate financial resources' shall be the minimum tangible net equity required of health care service plans pursuant to Section 12539 of the Government Code."

The failure of Medical Care Foundation to maintain the required tangible net equity made Medical Care Foundation ineligible to receive loan assistance from the state. The loan was granted by the Department of Health in violation of the above provisions of the Government Code and the Health and Safety Code.

SUMMARY OF COMMENTS OF OFFICIALS OF THE FOUNDATION COMMUNITY HEALTH PLAN

1. Foundation Community Health Plan is an innovative plan providing proven quality care, and overall, has operated much better than Medi-Cal fee-for-service.

2. We have a disproportionate number of sick people enrolled in the plan which demonstrates adverse selection. The fact that we enroll recipients in physicians' offices and pharmacies results in adverse selection.

3. The comparison made by the Department of Health between fee-for-service costs and Foundation costs is deficient in that it was assumed the same level of care was provided, administrative costs were not considered, and no allowance was made for adverse selection.

4. Although it is technically correct from an accounting standpoint to consider the risk pool as a liability, the Board of Trustees does not have any present intention to return the risk pool to the providers and therefore the risk pool should not be treated as a liability for the tangible net equity requirement.

SUMMARY OF COMMENTS OF
OFFICIALS OF THE
AMERICAN HEALTH CARE PLAN

1. With regard to the code section pertaining to medical records, in the case of AHCP, the plan would have to duplicate each medical record on a daily basis since the services are rendered in the subcontractee's offices and not at the offices of the plan. The logistics of gathering such information where the providers are scattered throughout the county will be enormous and difficult.

   - The benefit to be derived by AHCP is minimal in terms of the use of the data except for audit purposes. The AHCP cannot use such vast stores of data on any practical basis without incurring significantly great additional costs.

   - The law is inconsistent with the objectives of reducing costs since it is in fact increasing costs quite appreciably higher.

   - "A complete medical record" requires definition, unless the provisions of Section 51827 of the Administrative Code are here applicable.

2. Eligibility problems not only result in loss of revenues but increase costs of administering the program by the prepaid health plan and create bad relations with members and the public.

3. The plan is initiating a program to microfilm physician and patient treatment profiles. The program is expected to be operational in approximately 90 days.

VERBATIM RESPONSE
OF THE CHIEF DEPUTY DIRECTOR
OF THE DEPARTMENT OF HEALTH

State of California **Department of Health**

Memorandum

To : Phillips Baker
Audit Manager
Office of Auditor General
925 -L- Street, Room 750

Date : April 24, 1975

Subject: Exit Conference on Auditor General's Draft Report re American Health Care Plan and Foundation Community Health Plan

From : Office of the Director

The Department is currently conducting a comprehensive review of the entire rate setting function for health programs. This study will include PHP rate setting.

The Department is currently working with the State Attorney General on an inter-departmental task force in an attempt to resolve the application of Knox-Mills requirements* to prepaid health plans.

Although the Department appreciates the information provided in the section of the report labeled "Other Pertinent Information", we are concerned that these may be interpreted as findings. We would appreciate having that portion of the report clearly headed as only potential problems and that a complete investigation of these areas was not conducted by the Auditor General.

Stuart Snyder
Chief Deputy Director

*This refers to the requirement that a prepaid health plan must maintain a minimum tangible net equity based on the number of Medi-Cal recipients enrolled in the plan.